CACFP
Child and Adult Care Food Program
New York State Department of Health

CLAIM FOR REIMBURSEMENT
for Sponsoring Organizations of Day Care Homes

READ INSTRUCTIONS ON REVERSE carefully BEFORE completing claim. Submit one original, including original signature, of this form no later than the 10th of the month following the month being claimed, to: CACFP, NYS Dept of Health, Riverview Center, 150 Broadway FL 6 West, Albany, NY 12204. A copy of this form must be kept by the sponsor.

1. CACFP Agreement #

2. ADJUSTED CLAIM ☐ Yes (Only if claim for this month has been previously submitted.)

3. NAME OF SPONSOR	ADDRESS	CITY	STATE	ZIP CODE

4. TOTAL ADMINISTRATIVE EXPENDUTURES THIS PERIOD

	CATEGORIES	APPROVED BUDGET	EXPENDITURE Y-T-D
A.	Personnel		
B.	Operating Costs		
C.	Allocated Expenses		
D.	Travel		
E	Training		
F.	Professional Service		
G.	Capital Outlay		
H.	Other		
I.	Indirect		
	TOTAL		

COMMENTS: State Use Only

5. REIMBURSEMENT CATEGORY

	Number of Providers Claimed During Month	Average Daily Attendance
A. TIER 1		
B. TIER 2 HIGH (Serving only Tier 1 meals)		
C. TIER 2 LOW (Serving only Tier 2 meals)		
D. TIER 2 MIXED (Serving both Tier 1 & 2 meals)		
E. TOTALS:		

6. MAXIMUM NUMBER OF DAYS OF OPERATION FOR MONTH CLAIMED

7. PERIOD CLAIMED

Month	Year

TOTAL NUMBER OF MEALS SERVED TO:		A. Tier 1 Meals Served by Tier 1 Providers	B. Tier 1 Meals Served by Tier 2 Providers	C. Total Tier 1 Meals Served (A+B)	D. Total Tier 2 Meals Served	E. Total Meals Served (C+D)
8.	Breakfast					
9.	Lunch					
10.	Supper					
11.	Supplements					
12.	TOTALS					
13.	GRAND TOTAL AMOUNT DUE TO PROVIDERS					$

14. CERTIFICATION BY AUTHORIZED REPRESENTATIVE (a Completed Certificate of Authority Must Be On File)
I certify, to the best of my knowledge and belief, that this claim is true and correct in all respects; that records are available to support this claim; that it is in accordance with the terms and conditions of existing agreements; and that payment therefore has not been received. I recognize that I will be fully responsible for any excess amounts that may result from erroneous or neglectful reporting herein. Also, I am aware that deliberate misrepresentation or withholding of information may result in prosecution under applicable state and federal statutes.
I agree to contact CACFP if there are any changes in the approved application and sponsor agreement.

SIGNATURE _____ TITLE _____ DATE SIGNED _____

15. THIS FORM PREPARED BY:

NAME _____ TITLE _____ PHONE _____

FOR STATE USE ONLY

PROCESSED: REJECTED: DATE STAMP

Date ____ ____ ____ Date ____ ____ ____

Initials ____ ____ Initials ____ ____

All receipts, invoices and evidence of purchases must be retained and available for future audit for a period of 3 years after the submission of the final claim form for the fiscal year, or until any outstanding audits are resolved.	No further monies or other benefits may be paid out under this program unless this report is completed and filed as required by existing regulations (7 CFR 226).

GENERAL INSTRUCTIONS

A. Claim for Reimbursement for Sponsoring Organizations of Day Care Homes (DOH-3709) must be TYPEWRITTEN or HANDWRITTEN IN BLACK or BLUE INK.
B. A claim is for one month only. Report program information for one calendar month only on each claim form. Your amount of payment will be computed based on the current reimbursement rates for meal and sponsor administrative payments.
C. SIGN the claim before mailing to avoid delay in payment. Only original signatures of an authorized individual will be accepted.
D. All claims will be processed on a first-in, first-served basis. In order to get priority processing for the month, submit your claims by the 10th of the month following the claim month. Claims must be postmarked within 60 days of the last day of the month claimed to be eligible for payment. Adjusted claims must be postmarked within 90 days of the last day of the month claimed to be eligible for payment.
E. Your claim WILL BE RETURNED for correction, or significantly delayed if not properly completed. If you have any questions while completing the claim, contact the CACFP homes unit office for assistance.

SPECIFIC INSTRUCTIONS

The number of each instruction below corresponds with the numbered questions on the DOH-3709.

1. Enter your 4-digit CACFP agreement number. This number is issued to you on your application approval letter.
2. If you are adjusting a previous claim place an X in the box. An adjusted claim must include only the changes, the additional meals you are claiming or a negative amount for meals you have over-claimed. Do not repeat meals previously claimed. After completing #3, #5, and #6, indicate in #7 the month and year you are adjusting.
3. Enter the complete name and address of your organization. Your name and address will be compared with your original agreement. If it is a new address, you must send a short letter requesting a change of address. The request can be sent with the claim.
4. Enter your approved budget by category as it appears in your approved application. Enter your year-to-date expenditures in each category. Payment will be made for this claim based on the reimbursement formula for the number of homes claimed and NOT on reported expenditures. The most current expenditures available may be reported. The expenditure period DOES NOT need to match the claim month. An annual final report of actual expenditures through September 30 will be required by November 30 of the same calendar year. The Sponsor will be held to the FINAL report when determining eligibility for the lesser of three analysis (actual vs. budget vs. administrative reimbursement formula).
   NOTE: If actual expenditures are kept in a different format (i.e. Lotus spreadsheet), a copy of actual expenditures in that format may be attached. Please enter the words "see attached" in 4.
5. Enter the total number of providers in the appropriate tier reimbursement category for the month claimed. The sponsor prior to the end of the month claimed should have determined the tier of each provider. Under the Average Daily Attendance column, enter the average daily attendance for the providers in each tier category.
5. (E) Total each column under 5 A-D. Each column must be totaled as these numbers are used in the required monthly FNS 44 reporting process to USDA.
6. Enter the maximum number of days of operation for the month represented on the claim. This will be the highest number of days of operation for providers. For example, if there are one or more providers with weekend care and they provided care 30 days in a month, you would include all days and enter “30.”
7. Enter the month and year for which you are claiming.
8. Column A: Enter the total Breakfast meals served to Tier 1 children in a Tier 1 homes
   Column B: Enter the total Breakfast meals served to Tier 1 children in a Tier 2 homes
   Column C: Enter the total of both columns, A plus B, Total Tier 1 Meals Served
   Column D: Enter the total Breakfast meals served to Tier 2 children
   Column E: Enter the total of both columns, C plus D, Total Meals Served
9. Column A: Enter the total Lunch meals served to Tier 1 children in a Tier 1 homes
   Column B: Enter the total Lunch meals served to Tier 1 children in a Tier 2 homes
   Column C: Enter the total of both columns, A plus B, Total Tier 1 Meals Served
   Column D: Enter the total Lunch meals served to Tier 2 children
   Column E: Enter the total of both columns, C plus D, Total Meals Served
10. Column A: Enter the total Supper meals served to Tier 1 children in a Tier 1 homes
    Column B: Enter the total Supper meals served to Tier 1 children in a Tier 2 homes
    Column C: Enter the total of both columns, A plus B, Total Tier 1 Meals Served
    Column D: Enter the total Supper meals served to Tier 2 children
    Column E: Enter the total of both columns, C plus D, Total Meals Served
11. Column A: Enter the total Supplement meals served to Tier 1 children in a Tier 1 homes
    Column B: Enter the total Supplement meals served to Tier 1 children in a Tier 2 homes
    Column C: Enter the total of both columns, A plus B, Total Tier 1 Meals Served
    Column D: Enter the total Supplement meals served to Tier 2 children
    Column E: Enter the total of both columns, C plus D, Total Meals Served
12. Total each column for 8-11, under A-E. Each column must be totaled. These numbers are used in the required monthly CACFP reporting process to USDA.
13. Enter the grand total amount due to providers. This is the total from the “amount due” column on the Claim for Reimbursement Attachment for Sponsoring Organizations of Day Care Homes (DOH-3710) or Report 413, Claim Summary, from the NYS Homes System.
14. The certification should be read and then signed by someone who has been authorized to sign CACFP claims. A completed Certificate of Authority, including the person signing the claim must be on file with CACFP or the claim will be rejected. Also, if #14 is unsigned the claim will be rejected. To change or update the authorized person(s), send a Certificate of Authority to CACFP along with the claim or at any time prior to the submission of the claim.
15. Complete the name, title and telephone number of the person preparing the form. An unsigned claim will be rejected. Multiple copies of the claim are not required.

Mail the original of this form to: CACFP, NYS Dept of Health, 150 Broadway FL 6 West, Albany, NY 12204-2719